UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DONNELL D. SHREVE,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY,

Defendant.

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Case No. 05-72444

JUDGE PAUL D. BORMAN
UNITED STATES DISTRICT COURT

OPINION AND ORDER DENYING DEFENDANT AETNA INSURANCE AGENCY, INC.'S MOTION FOR ENTRY OF JUDGMENT

Presently before the Court is Defendant AETNA Insurance Agency, Inc.'s ("Defendant") Motion for Entry of Judgment. The Court held a motion hearing on June 14, 2006. Having considered the parties' briefs, and for the reasons stated below, the Court DENIES Defendant's Motion for Entry of Judgment.

I. FACTS

Plaintiff Donnell D. Shreve ("Plaintiff")[1], a full-time employee of Sysco Corporation[2] ("Sysco"), was eligible to participate in a long-term disability ("LTD") insurance plan (the

[1] Plaintiff is an individual and resident of Michigan. (Am. Compl. ¶ 1).

[2] Plaintiff was employed as an Order Selector, which required him to drive a pallet jack through a warehouse to retrieve items from shelves and load inventory onto pallets for delivery. (Pl.'s Resp. 4; Def.'s Br. 3).

"Policy") sponsored by Sysco and underwritten by Defendant.[3] (Pl.'s Resp. 3-4). Plaintiff was diagnosed with bilateral plantar fibromatosis[4] in February 2001 by his then-treating physician, Dr. Jerry Walden. (Pl.'s Resp. 4). Plaintiff's diagnosis was confirmed by Dr. Donald Wild ("Dr. Wild") through an MRI. (*Id*.). Plaintiff ceased working on February 18, 2001 because his condition worsened and began affecting both feet. (*Id*.). Dr. Wild noted that Plaintiff was capable of sedentary employment, but he indicated that the pain in Plaintiff's feet might last indefinitely and that it was unclear when Plaintiff would be allowed to pursue employment opportunities. (Def.'s Br. Ex. A, 6/26/01 Wild APS A 175). Plaintiff filed a claim with Defendant for LTD on June 20, 2001. (Pl.'s Resp. 4). His claim was approved and payments began on August 18, 2001. (*Id*.).

According to the terms of Defendant's LTD policy, a covered employee's claim "must give proof of the nature and extent of the loss. . . . [and the covered employee] must furnish such true and correct information as [Defendant] may reasonably request." (Def.'s Br. Ex. A, LTD Policy A 533). The policy also states that Defendant "will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while the claim is pending or payable." (*Id*. at A 534).

The LTD policy addressed how Defendant's benefit entitlement decision-making process works.

[Defendant] shall have discretionary authority to:

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[3] Defendant is a Connecticut corporation that does business in Michigan as a disability insurance provider. (Pl.'s Resp. 4; Am. Answer 2).

[4] Bilateral plantar fibromatosis is a condition of thickened fibrous tissue beneath the soles of the feet. (Pl.'s Resp. 4).

> determine whether and to what extent employees and beneficiaries are entitled to benefits; and
>
> construe any disputed or doubtful terms of this policy.
>
> [Defendant] shall be deemed to have properly exercised such authority unless [it] abuses its discretion by acting arbitrarily and capriciously.

(*Id*. at A 520). Defendant also has the "right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while the claim is pending or payable." (*Id*. at A 534).

A covered employee is eligible to receive benefits "[f]rom the date that you first become disabled and until Monthly Benefits are payable for 24 months." (Def.'s Br. Ex. A, LTD Policy A 523). Defendant's LTD policy states:

> [Y]ou will be deemed to be disabled on any day if:
>
> > you are not able to perform the **material duties** of your **own occupation** solely because of: disease or injury; and
> > your work earnings are 80% or less of your adjusted **pre-disability earnings**.
>
> After the 24 months that any Monthly Benefit is payable, you will be deemed to be disabled on any day if you are not able to work at any reasonable occupation solely because of: disease; or injury.

(*Id*.) (emphasis in original). The plan also describes when a covered employee's disability ends.

> Your disability ends on the first to occur of:
>
> > The date [Defendant] finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
> > . . . .
> > The date you are able to perform the duties of a reasonable occupation for compensation or profit equal to 20% or more of the adjusted predisability earnings and you refuse to do so, if such date occurs after the first 24 months that any Monthly Benefit is payable.

(*Id*. at A 524).

In March 2003, Plaintiff's then-treating physician, Dr. Alcala-Saenz submitted an Attending Physician Statement ("APS") to Defendant. (Def.'s Br. Ex. A, 3/22/03 Alcala-Saenz APS A 003). The APS indicated that Plaintiff had visible palpable masses on the bottom of his feet that were tender to touch. (*Id*.). Dr. Alcala-Saenz indicated that Plaintiff's symptoms were pain on rest and pain when standing or walking. (*Id*.). Dr. Alcala-Saenz opined that the diagnosis was bilateral plantar fasciitis and noted that he was "house confined." (*Id*.). The APS further indicated that Plaintiff had severe limitation of functional capacity, which meant that he was incapable of minimal sedentary activity, and because of his constant pain and lack of sleep, Plaintiff had difficulty concentrating and remembering. (*Id*.). Plaintiff's prognosis was marked as "guarded." (*Id*.).

At the conclusion of the 24-month disability benefits period, Defendant requested updated records and asked Plaintiff to submit a Claim Questionnaire ("Questionnaire"). (Def.'s Br. 5). Plaintiff's treating physician, Dr. Angelica Francu ("Dr. Francu"), submitted an APS on April 8, 2004, indicating that Plaintiff had bilateral plantar fasciitis as a primary diagnosis, and Dupuytren's contractures as a secondary diagnosis. (Def.'s Br. 6; Def.'s Br. Ex. A, 4/8/04 APS A 003). Dr. Francu also noted on the APS that there was no estimated date for Plaintiff to return to work,[5] and that his condition had regressed. (*Id*.). However, Dr. Francu indicated that

[5] The Court assumes that "estimated date to return to work" means the estimated date Plaintiff could resume his previous job responsibilities. This assumption stems from Dr. Francu noting the limitation on hours per day and days per week that Plaintiff can work.

Plaintiff could work six hours a day, five days a week, performing sedentary work.[6] (*Id.*). Further, Dr. Francu checked "no" to the question, "Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?" (*Id.*).

Plaintiff completed the Questionnaire on May 4, 2004. (*Id.*). On the Questionnaire, Plaintiff claimed that he was unable to walk and stand for extended periods of time, and also claimed that his feet were a constant source of pain. (Def.'s Br. Ex. A, Claim Questionnaire A 007). Plaintiff indicated on the Questionnaire that he is able to take care of personal care needs (i.e., grooming, dressing, etc.), and does laundry and cleaning on a regular basis. (*Id.*). Additionally, Plaintiff's Questionnaire answers indicated that he did not go for walks, though he goes fishing for fun. (*Id.*).

Defendant had its consulting medical director, Dr. William Hall ("Dr. Hall"), review Plaintiff's medical records and APS reports. After reviewing the medical records and APS reports, Dr. Hall concluded:

> I am not able to identify clinical references to activities prevented, delayed or interrupted by [Plaintiff] because of pain nor am I able to identify references to severe or recurring or intractable medication side effects experienced by him.
>
> [Plaintiff] has additional medical diagnoses of sleep apnea without complication and corrected by administration of C-PAP, obesity, and essential hypertension without complication and treated with administration of beta blocker and ACE-inhibitor medications. None of these diagnoses is attended by a medically limiting condition.
>
> In my opinion, [Plaintiff's] diagnosis of chronic and refractory left and right plantar faciitis complicated by Dupuytren's contractures at the same sites

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[6] Sedentary work activity was defined on the APS as "[m]oderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time." (Def.'s Br. Ex. A, Claim Questionnaire A 007).

> constitutes a medically limiting condition preventing sustained standing or walking.
>
> I am not able to identify an objective or absolute impediment to [Plaintiff's] pursing sustained (full-time) activity including work at a sedentary level of exertion.

(Def.'s Br. Ex. A, 1/12/04 Dr. Hall Claim Review Summary A 225). To assess Plaintiff's vocational capabilities, Defendant referred Plaintiff's claim for a skills analysis/labor market study. (Def.'s Br. 7). The skills analysis/labor market study found fifty potential employment opportunities within a fifty mile radius of Plaintiff's residence. (*Id*. at 8; Labor Market Survey A 185-95).

After reviewing Dr. Hall's summary and the vocational information, Defendant determined that Plaintiff no longer met the definition of disabled, as stated in its LTD policy. (Def.'s Br. Ex. A, Defendant's Notes A 343-49). Defendant informed Plaintiff by letter, on September 8, 2004, that his benefits would be terminated because he no longer satisfied the Policy's definition of disability, (Def.'s Br. Ex. A, 9/8/04 Letter A 096-101), and followed up the letter with a phone call on September 9, 2004. (Def.'s Br. Ex. A, Defendant's Notes A 343).

On September 15, 2004, Plaintiff appealed Defendant's decision to terminate his benefits. (Def.'s Br. Ex. A, 9/15/04 Letter from Pl. A 046). On the same day, Dr. Francu's office informed Defendant by telephone that Dr. Francu's April 8, 2004 APS form was completed incorrectly. Dr. Francu also sent a letter to Defendant on September 17, 2004, stating that after reevaluation , including a recent medical examination by Dr. Francu, Plaintiff remained unable to work.[7] (Def.'s Br. Ex. A, 9/17/04 Letter from Dr. Francu A 044). Defendant also received

[7] Dr. Francu's letter also informed Defendant that Plaintiff was admitted into the Emergency Room for uncontrolled hypertension. It appears that Plaintiff first went to Oakwood Healthcare

Plaintiff's September 16, 2004 emergency room intake sheet, indicating that Plaintiff had elevated blood pressure but was not experiencing pain at the time. (Def.'s Br. Ex. A, Emergency Physician Record A 077-083). However, prior to being transferred to the hospital, a physician examining Plaintiff at Oakwood Healthcare Center noted that Plaintiff was unable to stand, walk, or sit for very long, due to pain in his feet. (Def.'s Br. Ex. A, Oakwood Healthcare Center Form A 069).

On November 4, 2004, Defendant informed Plaintiff in a letter that his appeal was rejected. (Def.'s Br. Ex. A, 11/4//04 Letter to Pl. A 091). Defendant's letter stated that although Dr. Francu informed it on September 17, 2004 that Plaintiff was still unable to sit, stand, or walk without pain, "[Dr. Francu] did not indicate what specifically happened between April 8, 2004 and September 17, 2004 to change her mind." (*Id*.). The letter also mentioned that "[t]here is no documented change in your condition that would prevent you from performing sedentary work." (*Id*.).

On December 20, 2004, Dr. Francu again wrote to Defendant. (Pl.'s Resp. 10). In that letter, Dr. Francu indicated that Plaintiff's diagnosis remained the same, Plaintiff had no ability to work, and she considered him permanently disabled. (Def.'s Br. Ex. A, 12/20/04 Francu Letter to Def. A 282). Plaintiff's benefits remained terminated, resulting in this lawsuit.

II. ARGUMENTS

A. Defendant's Arguments

Defendant argues that judgment in the matter should be decided based upon the

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Center, (*See* A 069-071), before being transferred by ambulance to Oakwood Annapolis Hospital. (*See* A 077-083).

administrative record. Defendant claims that the Court must apply the arbitrary and capricious standard of review, which requires deference to Defendant's decision. Defendant avers that Plaintiff is unable to demonstrate any evidence that Defendant's decision was financially motived and that the alleged conflict of interest does not impact the standard of review. Defendant asserts that the evidence in the administrative record supports its finding that Plaintiff is not totally disabled.

B. Plaintiff's Arguments

Plaintiff responds that an actual conflict of interest exists because Defendant is the administrator and payor for the Plan. Plaintiff argues that Defendant arbitrarily refused to accept Dr. Francu's explanation for the apparent change in her medical opinion and therefore Defendant's decision to terminate benefits is based on a selective review of the records. Plaintiff contends that Dr. Francu attempted to correct a mistake in her April 2004 APS. Plaintiff claims that it was always Dr. Francu's medical opinion that Plaintiff was not able to work.

C. Defendant's Reply

Defendant replies that controlling case law does not support a finding that its decision to terminate benefits was biased. Defendant contends that even though it disagreed with the past-September 17, 2004 medical opinion of Dr. Francu, its decision was reasonable and based upon the evidence available in the record. Defendant argues that Dr. Francu provided no new evidence in the form of office notes or records from her subsequent exams to support her contention that Plaintiff has "no ability to work."

III. ANALYSIS

A. Standard of Review

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), the Supreme Court held that an administrator's decision to deny benefits must be reviewed *de novo* unless the plan gives the administrator discretionary authority to determine eligibility for benefits. When the plan administrator has discretionary authority to determine eligibility for benefits, "the highly deferential arbitrary and capricious standard of review is appropriate." *Borda v. Hardy, Lewis, Pollard, & Page, P.C.*, 138 F.3d 1062, 1066 (6th Cir. 1998) (internal citation omitted). However, the arbitrary and capricious standard of review is not "without some teeth." *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003).

> 'Deferential review is not no review,' and 'deference need not be abject.' [The court has] an obligation under ERISA to review the administrative record in order to determine whether the plan administrator acted arbitrarily and capriciously in making ERISA benefits determinations. This obligation inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision[,] as long as the plan was able to find a single piece of evidence – no matter how obscure or untrustworthy – to support a denial of a claim for ERISA benefits.

Id. (quoting *Hess v. Hartford Life & Accident Ins. Co.*, 274 F.3d 456, 461 (7th Cir. 2001).

A plan does not need to use the words "discretionary authority" to constitute a clear grant of discretion to the plan administrator. *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 555 (6th Cir. 1998):

> [District courts should focus on the] "breadth of the administrators' power – their authority to determine eligibility for benefits or to construe the terms of the plan. While 'magic words' are unnecessary to vest discretion in the plan administrator and trigger the arbitrary and capricious standard of review, [the Sixth Circuit] has consistently required that a plan contain a clear grant of discretion to the administrator to determine benefits or interpret the plan.

Id. (internal citations omitted).

A plan administrator's decision will not be deemed arbitrary and capricious so long as "it

is possible to offer a reasoned explanation, based on the evidence, for a particular outcome." *Davis v. Ky. Finance Cos. Ret. Plan*, 887 F.2d 689, 693 (6th Cir. 1989). The arbitrary and capricious standard is the least demanding form of judicial review of an administrative action. *Morrison v. Marsh & McLennan Cos*., 439 F.3d 295, 300 (6th Cir. 2005); *see also Williams v. Int'l Paper Co*., 227 F.3d 706, 712 (6th Cir. 2000).

B. Discussion

At the outset, the Court finds that Defendant's Policy gives Defendant discretionary decision-making authority, and thus the Court should apply the arbitrary and capricious standard of review. Although the policy need not use the phrase "discretionary authority," Defendant's Policy does so. Defendant's Policy states that it has "discretionary authority to . . . determine whether and to what extent employees and beneficiaries are entitled to benefits." (Def.'s Br. Ex. A, LTD Policy A 520).

Defendant argues that Plaintiff cannot show that its decision was motivated or influenced by a conflict of interest, aside from the fact that Defendant underwrites the benefits at issue and makes the decision whether to issue those benefits. Defendant further argues that it has a reasoned explanation for its decision to deny Plaintiff's claim and that the Court must uphold that decision. Defendant contends that the administrative record supports its decision that Plaintiff is able to work at a reasonable occupation, despite his injury.

Plaintiff responds that an actual conflict of interest exists, and Defendant's bias in refusing to consider Dr. Francu's explanation – that she made a mistake on her April 2004 APS and that Plaintiff is unable to work in any capacity – should be factored into the Court's analysis. Plaintiff avers that Defendant cannot arbitrarily refuse to credit Plaintiff's reliable evidence,

which, in this case, is the opinion of his treating physician. Additionally, Plaintiff claims that Defendant performed a selective review of the records and evidence because Defendant ignored Dr. Francu's subsequent letters which stated that Plaintiff has no ability to work. Plaintiff asserts that Defendant also chose to rely entirely on its file reviewer, who was not an independent expert, and failed to send Plaintiff for an independent medical examination following the report of its medical reviewer. Plaintiff cites *Moon v. Unum Provident Corp*., 405 F.3d 373 (6th Cir. 2005), and *Evans v. Unumprovident Corporation*, 434 F.3d 866 (6th Cir. 2006).

In the instant case, Defendant both funds and administers the plan at issue. Accordingly, it incurs a direct expense as a result of the allowance of benefits, and it benefits directly from the denial or discontinuation of benefits. Because of this dual role, "the potential for self-interested decision-making" is an actual conflict. "[A] conflict of interest exists when the insurer both decides whether the employee is eligible for benefits and pays those benefits." *Evans*, 434 F.3d at 876 (internal citation omitted). When there is a conflict of interest, "the conflict must be weighed as a factor in determining whether this is an abuse of discretion." *Firestone*, 489 U.S. at 115. Thus, the Court will consider Defendant's conflict of interest as a factor in its analysis.

In support of its decision to terminate Plaintiff's disability benefits, Defendant mainly relied on a few of the documents in the record. Defendant relied on Plaintiff's Questionnaire, which stated that he could not do extended walking or standing, but was able to take care of his personal needs, and chores, like laundry and cleaning, and fishing. Defendant also relied on Dr. Francu's April 2004 APS, which stated that Plaintiff was capable of sedentary work activity, with the use of up to 10 pounds of force, for six hours per day, five days per week. Also noted in the APS was that Plaintiff could occasionally walk or stand for brief periods of time while at

work. Dr. Francu's APS was consistent with Dr. Wild's APS, which stated that Plaintiff could work but needed to sit frequently.[8] Additionally, Defendant relied heavily on Dr. Hall's review and summary of Plaintiff's medical records. Defendant did not rely on Dr. Francu's September 16, 2004 and December 20, 2004 letters, nor her overall medical change of opinion, because it deemed the letters and the change of opinion as not credible. Defendant reasoned that Dr. Francu did not include office examination notes or other medical records to support her most recent medical opinion, which was contrary to her April APS.

Plaintiff argues that Defendant's decision was arbitrary and capricious because Dr. Francu, not Dr. Hall, was best able to determine the severity of Plaintiff's disability. Further, Plaintiff argues that Defendant selectively reviewed the records when it dismissed Dr. Francu's September and December 2004 letters in favor of Dr. Hall's medical review summary, which did not take into account Dr. Francu's later – and more current – medical evaluation of Plaintiff.

In *Moon v. Unum Provident Corporation*, the Sixth Circuit held that the termination of the plaintiff's disability benefits was arbitrary and capricious where the defendant relied solely on the staff physician's opinion, rather than on the plaintiff's own physicians. The court held that "the only medical opinion contrary to [the plaintiff's treating physician] was [the staff physician]. He arrived at his opinion not upon examination of [the plaintiff], but rather upon . . . a selective review of the administrative record." 405 F.3d at 381. Indeed, in a subsequent decision awarding attorney fees to Moon's attorney, the Sixth Circuit reiterated:

[8] Although Dr. Wild stated that Plaintiff could work but needed to sit frequently, he also felt that Plaintiff could not pursue employment opportunities at the time his APS was written.

> Without question, UNUM'S wholesale adoption of the opinion of an interested physician, who based his findings on selective information in the administrative record and did not examine Moon, is misconduct that supports our decision to weigh this factor against UNUM.

Moon v. UNUM Provident Corp., Case No. 05-1974, slip op. at 6 (6th Cir. Jun. 29, 2006).

In *Evans v. Unumprovident Corp*.,[9] the court found that the plan administrator's decision to have the plaintiff's file reviewed, rather than conducting a physical exam, was another factor to consider in the assessment of whether the defendant acted in an arbitrary and capricious manner. 434 F.3d at 877. The court also opined that the failure to conduct a physical examination, especially when the defendant explicitly reserves the right to do so, possibly raises questions of thoroughness and accuracy in the determination of benefits. *Id*. The court held that:

> Defendant's reliance solely on file reviews by its in-house physicians is questionable in light of the critical credibility determination is made in those file reviews, the factual inaccuracies contained therein regarding plaintiff's treatment history, and the fact that the file reviews categorically dismissed the reliable opinion of plaintiff's treating physicians that the stress factor militated against plaintiff's resumption of her administrative position.

Id. at 880.

Here, Plaintiff's treating physician originally stated that Plaintiff could work six hours a day, five days a week. After Defendant terminated the benefits, treating physician again examined Plaintiff and submitted letters to Defendant notifying them that, after reevaluating Plaintiff, he was not able to work. Dr. Francu's subsequent letter notifying Defendant of her reevaluation stated that her earlier opinion was a mistake. This, while Dr. Hall agreed with Dr. Francu's original medical opinion in her April 2004 APS, that initial opinion was changed after a

[9] The Court is well aware of the different titling of identical defendants in the above mentioned Sixth Circuit published decisions. The Court follows the Sixth Circuit titling as contained in the official F.3d reports.

subsequent visit. Dr. Francu did not submit office examination notes or other medical records to support her September 16, 2004 medical opinion. Neither Dr. Hall, nor any other doctor hired by Defendant ever conducted an examination of Plaintiff.

It is unclear whether Dr. Hall is an independent medical reviewer or somehow affiliated with Defendant. It is clear that Defendant did not conduct an independent medical evaluation after Dr. Francu informed it of her mistake/change of opinion; Defendant had reserved the right to do so. Although Dr. Francu never submitted office examination notes or other medical records to document the change in her medical opinion of Plaintiff, the fact remains that she performed another medical evaluation on Plaintiff on September 16, 2004. It was her opinion, as of that date, that Plaintiff had no ability to work, walk, sit or stand. Dr. Francu believed that Plaintiff's plantar fasciitis prognosis was poor and that he continued to regress. Regardless of whether Dr. Francu submitted notes or records to document her medical evaluation, Defendant was aware of the reevaluation and of Dr. Francu's medical opinion of Plaintiff, and that her change of opinion was based on the new evaluation. If Defendant believed that Dr. Francu's medical opinion was unsupported because she did not specifically state what occurred to change her mind, it should have conducted its own independent medical evaluation, rather than ignoring her medical opinion and subsequently denying Plaintiff's appeal. This circuit has previously held that "[p]lan administrators . . . may not arbitrarily refuse to credit a claimant's reliable evidence, including the *opinions* of a treating physician." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003) (emphasis added). Here, instead of relying on Dr. Francu's most

recent medical opinion, Defendant relied on its consulting medical director's opinion,[10] even in light of both Dr. Francu's statement that her April 2004 APS was made in error, and, Dr. Francu's medical opinion based on her September 16, 2004 evaluation of Plaintiff.

Accordingly, after considering Dr. Francu's September 16, 2004 medical opinion of Plaintiff, Defendant's decision not to perform an independent medical evaluation, and Defendant's conflict of interest, the Court concludes that Defendant acted arbitrary and capriciously in terminating Plaintiff's disability benefits.

III. CONCLUSION

For the reasons stated, the Court DENIES Defendant's Motion for Entry of Judgment. Give this decision, the Court will permit Plaintiff to re-file its out-of-time Motion for Summary Judgment within two weeks from the date of this opinion, and thereafter permit Defendant to file a Response.

SO ORDERED.

s/Paul D. Borman
PAUL D. BORMAN
UNITED STATES DISTRICT JUDGE

Dated: July 12, 2006

[10] The Court notes that Dr. Hall suggested in his summary that Defendant request Plaintiff's medical records and an APS on April 1, 2005. Defendant rejected Plaintiff's appeal before April 1, 2005, and never requested the additional information.

CERTIFICATE OF SERVICE

Copies of this Order were served on the attorneys of record by electronic means or U.S. Mail on July 12, 2006.

s/Denise Goodine
Case Manager